BUREAU OF DEVELOPMENTAL DISABILITIES SERVICES

SERVICE DEFINITIONS AND STANDARDS MANUAL

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These BDDS Service Definitions supercede all previous definitions for these services

These service definitions apply to all BDDS Services

These BDDS Service Definitions are effective 07-01-06

GENERAL INFORMATION

BUREAU OF DEVELOPMENTAL DISABILITIES SERVICES

The Bureau of Developmental Disabilities Services (BDDS) defines, funds, and monitors a variety of supported living services and supports for individuals who are eligible for developmental disabilities services and who reside in Indiana. BDDS is part of the Division of Disability and Rehabilitative Services (DDRS) which is a division of the Family and Social Services Administration (FSSA). BDDS functions under authority of Title XII of the Indiana Code. The Bureau of Developmental Disabilities Services has the responsibility of providing direction and impetus in implementing a sound, cohesive service delivery system for persons with developmental disabilities and their families. One of these responsibilities is reviewing and approving providers to deliver services to individuals who are eligible for developmental disabilities services.

SERVICES AVAILABLE THROUGH BDDS FUNDING STREAMS

The Division of Disability and Rehabilitative Services (DDRS) facilitates the delivery of services to consumers from provider agencies whose services have been approved by the Bureau of Developmental Disabilities Services (BDDS) and the Community Residential Facilities Council (CRFC).

A variety of services and supports are funded through BDDS by both state and federal dollars. Services and supports are available to individuals who have been determined eligible by the BDDS Service Coordinator or Vocational Rehabilitation Services (VR) staff. In addition, individuals may qualify to receive services through the Medicaid Waiver Home and Community-Based Services Waiver Programs. Individuals who wish to apply for services should contact the nearest BDDS District Office.

Services are designed to meet the unique needs and desires of the individuals, enabling them to live and work in the community in the least intrusive manner consistent with their needs.(These services and supports incorporate a holistic approach that unites services and supports related to the individual's home setting with services and supports related to the individual's job.) With the assistance of family, the Case Manager, BDDS Service Coordinators and others, the individuals can create individualized support plans that address their needs and reflect their interests.

Services and supports may occur in a variety of living, vocational or habilitation arrangements, including settings where housemates have rotating staff members. The specific services and supports an individual receives are planned to fit the specific needs and interests of each individual. Each individual may receive a mixture of the services and supports available**.** The specific services and supports delivered determine the reimbursement rates.

Services available through BDDS:

1. Adult Day Services
2. Adult Foster Care Services
3. Applied Behavior Analysis Services
4. Behavioral Support Services
5. Case Management Services
6. Children's Foster Care Services
7. Community-Based Sheltered Employment Services
8. Community Transition Supports
9. Crisis Assistance Services
10. Day Services
11. Environmental Modification Supports
12. Facility-Based Sheltered Employment Services
13. Family and Caregiver Training Services
14. Health Care Coordination Services
15. Music Therapy Services
16. Occupational Therapy Services
17. Person Centered Planning Facilitator Services
18. Personal Emergency Response Systems Supports
19. Physical Therapy Services
20. Pre-Vocational Services
21. Recreational Therapy Services
22. Rent and Food for Unrelated Live-in Caregiver Supports
23. Residential Habilitation and Support Services
24. Residential Living Allowance and Management Services
25. Respite Care Services
26. Specialized Medicaid Equipment and Supplies Supports
27. Speech/Language Therapy
28. Supported Employment (Title XX)
29. Therapy Services
30. Transportation

BDDS' EXPECTATIONS OF SERVICE PROVIDERS

A. Services and supports for individuals shall be based on an individualized Person-Centered Planning process that considers the individual's long term and short term interests and needs which must be reflected in the Individualized Support Plan. 460 IAC 7.
B. Services and supports for individuals shall be integrated into the community, with services and supports occurring in the most inclusive setting possible.
C. Services and supports shall be designed to increase the individual's personal autonomy and independence.
D. Services and supports shall be provided in compliance with the DDRS Provider and Case Management Standards.

APPLICATION PROCESS FOR SERVICE PROVIDERS

The application process varies, depending on the specific service(s) the prospective provider requests to deliver. There are two application tracks - (1) the Application and Written Service Proposal Process and (2) the Application/Credentialing Process.

Provider Orientation
Attendance at an orientation session for prospective providers is required. There are two different orientation sessions offered, one includes information regarding the BDDS services that require a detailed written proposal and one includes information regarding the BDDS services that only require submission of specific documentation.

The orientation sessions are scheduled every quarter of the calendar year and alternate between the proposals requiring the detailed written proposal and the proposals that only require submission of specific documentation.

To receive an application, any new (not a current provider of services for BDDS) person/company representative must attend the mandatory Orientation Sessions.

Application packets will be distributed at the orientation sessions. BDDS will accept only those application packets from new prospective providers who have attended the orientation sessions.

If an existing provider wants to add new services and does not attend the Orientation Sessions, the provider may request the application form and submit only during the designated time frames.

BDDS Services **requiring detailed written proposals**:

Adult Day Service
Adult Foster Care
Child Foster Care
Community Based Sheltered Employment Services
Crisis Assistance Services
Day Services
Facility Based Sheltered Work
Family and Caregiver Training
Pre-Vocational Services
Residential Habilitation and Support
Rent/Food for Live-In, Unrelated Caregiver
Residential Habilitation and Support: Which include:
    Community Transitional Supports
    Residential Living Allowance and Management
Respite Care (Attendant Care)
Supported Employment Follow Along (Title XX)
Transportation-Residential Services
Transportation (State Contract - Title XX)

BDDS Services **requiring submission of documentation only**:

Applied Behavioral Analysis
Behavioral Support Services
Environmental Modifications
Environmental Modifications Assessment, Inspection, and Training
Health Care Coordination
Music Therapy
Occupational Therapy
Person-Centered Planning Facilitation
Personal Emergency Response Systems
Physical Therapy
Recreational Therapy
Respite (Home Health Agency/Individual)
Specialized Medical Equipment/Supplies (SMES)
SMES Assessment, Inspection, and Training
Speech/Language Therapy
Therapy Services

APPROVAL PROCESS

1. If a written service proposal is required,
   a. The applicant must submit **one (1) original and three (3) copies** of a the entire written proposal and specified documents/credentials noted on the application and in the BDDS/waiver manuals, plus:
      - The one (1) original and three (3) copies must be identical presentations of the proposal.
      - The proposal must be submitted in the sequence listed within the application.
      - Each section must be clearly marked and labeled with tabs and within binders.
      - The application needs to be submitted during the appropriate timeframe to:

        MS 18
        Program Review Committee
        Bureau of Developmental Disabilities Services
        P.O. Box 7083, Rm. W453
        Indianapolis, IN 46207-7083

      - The procedures for approval or denial of any application are controlled through 460 IAC 6-6-3(c).
      - The Program Review Committee will review the information submitted.
      - For the initial submission, if information is lacking, a letter detailing questions, concerns and any other information is needed to complete the proposal or application is sent to the applicant.
      - If after two submissions, required information is still lacking, BDDS will notify the applicant that the application does not meet the approval requirements of 460 IAC 6-6-3 (b).
      - When the application meets the requirements established through the Program Review Committee, BDDS will submit a report recommending approval to the Community Residential Facilities Council (CRFC) for their review and action.
      - CRFC shall either
        i. Approve the applicant for a period not to exceed 3 years, or
        ii. Deny approval to an applicant that does not meet approval requirements of 460 IAC 6-6-3(b).
      - Appeal process. If an applicant believes it is adversely affected or aggrieved by the BDDS determination, the applicant may request administrative review of the determination. Such a request shall be made in writing and filed with the director of BDDS within fifteen (15) days after the applicant receives written notice of the BDDS determination, per 460 IAC 6-6-3 (d).

2. If written service proposal is **not** required,

   a. The application must be submitted in the sequence listed within the application. Each section must be clearly marked and labeled with tabs and within binders. The application needs to be submitted during the appropriate timeframe to: (see the application for details):

      MS 18
      Program Review Committee
      Bureau of Developmental Disabilities Services
      P.O. Box 7083, Rm. W 453
      Indianapolis, IN 46207-7083

   b. The procedures for approval or denial of any application are controlled through 460 IAC 6-6-3(c).

      - Provider relations will review the information submitted.
      - For the initial submission, if information is lacking, a letter detailing questions, concerns and any other information is needed to complete the proposal or application is sent to the applicant.
      - If after two submissions, required information is still lacking, BDDS will notify the applicant that the application does not meet the approval requirements of 460 IAC 6-6-3 (b).
      - When the application meets the requirements established through the Program Review Committee, BDDS will submit a report recommending approval to the Community Residential Facilities Council (CRFC) for their review and action.
      - CRFC shall either

        iii. Approve the applicant for a period not to exceed 3 years, or
        iv. Deny approval to an applicant that does not meet approval requirements of 460 IAC 6-6-3(b).

      - Appeal process. If an applicant believes it is adversely affected or aggrieved by the BDDS determination, the applicant may request administrative review of the determination. Such a request shall be made in writing and filed with the director of BDDS within fifteen (15) days after the applicant receives written notice of the BDDS determination, per 460 IAC 6-6-3 (d).

   c. Approval does not guarantee that consumers will contract for services with the provider.

   d. The Bureau of Developmental Disabilities Services or its designee will regularly monitor the provider's compliance 460 IAC 6.

   e. For providers who do not remain in compliance with the requirements established in 460 IAC 6, the bureau may impose sanctions, up to and including termination of approval to serve specific individuals or termination of approval to provide any services and supports, per 460 IAC 6-7-2, 3, 4, 5.

OUTCOME-BASED MONITORING BY DDRS

The Division of Disabilities and Rehabilitative Services (DDRS) shall conduct follow-up reviews and request written reports in order to monitor provider's service delivery. Part of this process shall include comparing expected outcomes detailed in the Individualized Support Plan with actual results.

RENEWAL OF APPROVED PROVIDER STATUS FOR PROVIDERS OF SUPPORTED LIVING SERVICES

1. The provider shall submit a written request for renewal of BDDS' approval at least 90 days prior to the expiration date of the current approval, the request shall be mailed to:

   MS 18
   Provider Relations
   Bureau of Developmental Disabilities Services
   P.O. Box 7083
   Indianapolis, IN 46207-7083

2. Upon receiving a request for renewal of approved status, the BDDS shall send an assessment of provider performance to be completed by the provider, also at this time the BDDS shall determine whether a provider continues to meet the requirements of 460 IAC 6.

3. The BDDS determination on renewal of approval shall be based on verification that shall be based on verification that

   (1) The provider's operations have been surveyed by BDDS or its designee either:

   (A) Within the preceding twelve (12) months; or

   (B) As part of the renewal process, **AND**

   (2) There are no outstanding issues that seriously endanger the health or safety of an individual receiving services from the provider per 460 IAC 6-6-5 (c).

4. In considering a request for the renewal of approval, the BDDS shall either:

   - Approve the applicant for a period not to exceed three (3) years; or
   - Deny approval to an applicant that does not meet the approval requirements of 460 IAC 6.

5. If BDDS recommends renewal of the provider, BDDS will submit the assessment of provider performance received from the provider and a report to the Community Residential Facilities Council for its approval, per 431 IAC 7- 6-5. The report will note the name of the provider, service(s) recommended for approval and a note that the provider submitted all required documentation to meet the requirements of that service(s).

6. The BDDS shall notify a provider in writing of the BDDS' determination at least thirty (30) days prior to the expiration of the provider's approval per 460 IAC 6-6-5 (e).
7. If a provider has requested the renewal within the required timeframe, and if BDDS does not act upon a provider's request for renewal of approved status before the expiration of the provider's approved status, the provider shall continue in an approved status until such time as the BDDS acts upon the provider's request for renewal of approved status. 460 IAC 6-6-5-(2)(f).
8. If a provider is adversely affected or aggrieved by BDDS' determination, the provider may request administrative review of the determination. The request shall be made in writing and filed with the director of the division within fifteen (15) days after the provider receives written notice of the determination. Administrative review shall be conducted pursuant to IC 4-21.5
9. Failure to request a renewal of BDDS approval could result in a provider losing approved status.

MONITORING SERVICE DELIVERY AND DOCUMENTATION OF SERVICES

Case Managers have the responsibility to be the first level of monitoring service delivery and documentation of services to assure that services occur as authorized in the Individualized Support Plan and per the service definitions. The Service Coordinators in the local BDDS District Offices also help to monitor that services are being delivered effectively and in a timely fashion. The Bureau of Quality Improvement Services (BQIS) has the greatest responsibility in monitoring service delivery and reviewing documentation as part of its survey process. The BQIS findings are of paramount importance in determining if a provider has sanctions placed against the agency or if a provider can remain an approved provider. A Provider may not have its approved status renewed without a recent BQIS survey of that provider.

TERMINATION OF SERVICES

A provider shall give an individual and an individual's representative at least sixty (60) days written notice before terminating the individual's services, if the services being provided to the individual are of an on-going nature.

If the provider is providing any services to the individual, besides case management services, before terminating services the provider shall:

(a) participate in the development of a new or updated ISP prior to terminating services, and
(b) continue providing services to the individual until a new provider providing similar services is in place.

If the provider is providing case management services to the individual, before terminating services the provider shall:

(c) participate in a team meeting in which the individual's new provider providing case management is present, and
(d) coordinate the transfer of case management services to the new provider providing case management services.

SERVICE DEFINITIONS

The criteria established by these service definitions and in 460 IAC 6 are in addition to the criteria established by accreditation entities. Service Providers must remain in compliance with these definitions and 460 IAC 6. **All provider entities must be approved for the particular service or support by BDDS and the Community Residential Facilities Council before implementing a specific service or support.**

Adult Day Services

Adult Day Services are community-based group programs designed to meet the needs of adults with developmental disabilities through individual plans of care. These structured, comprehensive, non-residential programs provide health, social, behavioral, recreational, therapeutic activities, supervision, support services and personal care. These services must be provided in a congregate, protective setting, based upon the assessment of the appropriate level of services. There are three levels of Adult Day Services – Basic, Enhanced, and Intensive

Participants attend Adult Day Services on a planned basis with a minimum of 3 hours to a maximum of 12 hours daily service.

Meals and/or nutritious snacks are required. The meals cannot constitute the full daily nutritional regimen. Each meal must meet 1/3 of the daily Recommended Dietary Allowance.

Unit of Service

½ day

Allowable Activities

Reimbursable activities through Adult Day Services include:

Basic Adult Day Services (Level 1)

- Monitor and/or supervise all activities of daily living (ADLs) [defined as dressing, bathing, grooming, eating, walking and toileting] with hands-on assistance as needed
- Comprehensive, therapeutic activities
- Health assessment and intermittent monitoring of health status
- Appropriate structure and supervision for those with mild cognitive impairment

- **Maximum ratio = 8 individuals to 1 support staff**

Enhanced Adult Day Services (Level 2)

- All activities included in Basic (Level 1)
- Hands-on assistance with 2 or more ADLs or hands-on assistance with bathing or other personal care
- Health assessment with regular monitoring or intervention with health status
- Dispense or supervise the dispensing of medications to individuals
- Psychosocial needs assessed and addressed, including counseling as needed for individuals and caregivers
- Therapeutic structure, supervision and intervention for those with mild to moderate cognitive impairments
- **Maximum ratio = 6 individuals to 1 support staff**

Intensive Adult Day Services (Level 3)

- All activities included in Basic (Level 1) and Enhanced (Level 2)
- Hands-on assistance or supervision with all ADLs and personal care
- One or more direct health intervention(s) required
- Rehabilitation and restorative services including Physical Therapy Services, speech therapy, and/or Occupational Therapy Services coordinated as available
- Therapeutic intervention to address dynamic psychosocial needs such as depression or family issues affecting care
- Therapeutic interventions for those with moderate

to severe cognitive impairments

- **Maximum ratio = 4 individuals to 1 support staff**

Activities not allowed

Reimbursement is not available through adult day services for the following:

- Skilled nursing services that are available through the Medicaid State Plan
- Services not specified in the Individualized Support Plan
- Case management services
- Residential, vocational and/or educational services otherwise provided through supported living services or generic services

Service Standards

Adult day services must be reflected in the Individualized Support Plan

- Services must address needs identified within the person centered planning process and be outlined in the Individualized Support Plan
- Individualized Support Plan must be based upon the Level of Service Assessment Tool administered by the case manager or the service coordinator
- Risk Management assessment of each individual
- Services must reflect purposeful and meaningful activities for each individual, as reflected within the Individualized Support Plan

Provider Qualifications

To be approved to provide Adult Day Services, an applicant shall:

- Be an approved Adult Day Services provider for Medicaid waiver in-home services
- Provide 40 square feet within the facility for each individual being served
- Include a Registered Nurse or Licensed Practical Nurse as Consultant or as member of the staff
- Include a Registered Dietitian as Consultant

when the facility prepares meals/snacks on site as part of staff

- Cooperate with an on-site inspection to assure all required standards are met, through the BDDS Adult Day Service Standards and Guidelines
- Participate with, and keep record of, the County Health Building Inspection and Fire Inspection.

Documentation Standards

Adult Day Services documentation must include:

- Services and goal-related activities outlined in Individualized Support Plan, including Plans to address health and safety risks of each individual, strategies for assisting in personal hygiene, correct posture and positioning, dining requirements, diet restrictions and behavioral issues.
- Evidence that the Level of service provided is required by the individual
- Attendance record documenting the date of service and the number of units of service delivered that day
- Monthly record of Menus, if meals prepared on site
- Facility Floor Plan, indicating dimensions of rooms used by the individuals to receive services
- Emergency Plans, including evacuation plans and evidence of fire and tornado drills; and contact numbers readily available for immediate use
- A brief description of the daily operation of the services must be available for families, individuals, including purpose and utilization of volunteers
- Documentation in compliance with 460 IAC 6

Adult Foster Care Services	Adult Foster Care Services means a living arrangement in which an individual lives in the private home of a principal caregiver who is unrelated to the individual Necessary support services are provided by the principal caregiver (i.e. "foster parent") as part of Adult Foster Care Services. Only agencies may be foster care providers, with the foster care settings being certified, supervised, trained, and paid by the approved agency provider **Separate payment will not be made for homemaker or chore services furnished to an individual receiving Adult Foster Care Services, since these services are integral to and inherent in the provision of adult foster care services** The total number of individuals living in the home who are unrelated to the caregiver may not exceed four. An individual in level 1 may reside with a family and up to 3 other individuals (no more than 4 total). An individual in level 2 may not reside with more than 1 other individual in the Adult Foster Care program. An individual in level 3 may not reside with any other individuals in the AFC program
Unit of Service	1 day of services
Rates	There are three levels of rates. The Individualized Support Team (IST) determines what level of supports are required for the individual, based on what services an individual would utilize if foster care services were not available A Service Planner must be completed showing the services and amounts of services required in another setting. This will help demonstrate the cost effectiveness of the individual receiving Adult Foster Care services. If there are changes in the individual's condition that may call for a change in the level of service, the IST will redetermine what level of supports the individual requires, with ultimate approval given according to who can approve a specific level of service Level 1 - Approved by Service Coordinator Level 2 - Approved by District Mgr. Level 3 - Approved by Central Office

	Issues to consider in determining which tier of services the individual receives include the amount of time the foster family will need to spend in 1) health and safety management; 2) challenges and experiences aimed at increasing a person's ability to live a lifestyle that is compatible with the person's interest and abilities; 3) modification or improvement of functional skills; 4) guidance and direction for social/emotional support; and 5) facilitation of both the physical and social integration of a person into typical family routines and rhythms
Activities Allowed	Reimbursable activities under Adult Foster Care Services include, but are not limited to, the following: • Personal care and services • Homemaker/chore services • Attendant care and companion care services • Medication oversight • Respite for the foster parent (funding for this respite is included in the per diem paid to the service provider, the actual service of Respite Care may not be billed in addition to the per diem) • Other appropriate supports as described in the Individualized Support Plan
Activities Not Allowed	Activities that are not reimbursable through Adult Foster Care Services include: • Residential Living Allowance and Management Services are not available to individuals receiving Adult Foster Care • Services provided in the home of a caregiver who is related by blood or marriage, in any degree, to the individual
Service Standards	Adult Foster Care Services must be reflected in the Individualized Support Plan • Services must address the needs (i.e. developmental needs, vocational needs, etc.) identified in the person centered planning process

and be outlined in the Individualized Support Plan

Other services such as Day Services, etc. may be added to the individual's Cost Comparison Budget or State line Budget; however, reimbursement would be through those services, not through Adult Foster Care Services

- 10% of the total per diem amount is intended for use by the provider for respite care as needed. It is the provider's responsibility to approve any providers of respite chosen by the family or the individual

- The provider determines the total amount per month paid to the foster parent

- The agency's administrative/supervision fee comes from the remaining total amount and includes the following duties:
    a. Publish written policies and procedures regarding foster parent support services
    b. Maintain financial and service records to document services provided to the individual
    c. Establish a criteria for the acceptance of the foster parent, screen potential foster parents for qualities of stability, maturity, and experiences so as to ensure the safety and well being of the individual, and obtain a criminal background and reference check
    d. Coordinate/provide adequate initial training and ongoing training, consultation and supervision to the foster parent
    e. Provide for the safety and well being of the individual by inspection of environment for compliance with DDRS policies and procedures, including, but no limited to, the provider and case management standards found in 460 IAC 6.
    f. Reimburse foster parent

Provider Qualifications — To be approved to provide Adult Foster Care Services, an applicant shall:

- Be an entity approved to provide supported living services under 460 IAC 6; and

- Certify that, if approved, the entity will provide adult foster care services using only persons who meet the qualifications set out in 460 IAC 6-14-5

Documentation Standards

Adult Foster Care Services documentation must include:

- Services outlined in the Individualized Support Plan

Documentation by Providers:

- Written policies and procedures, including for screening and accepting foster parents
- Maintain financial and service records to document services provided to the individual
- Document provision of training to foster parents according to agency policies/procedures.
- Reimbursement of foster parent

Documentation by Families:

- One entry per day detailing an issue concerning the individual

- The entry should detail any outcome-oriented activities, tying those into measurable progress toward the individual's outcome (as identified in the ISP)

- The entry should also include any significant issues concerning the individual, including:

    - Health and safety management
    - Developmental challenges and experiences aimed at increasing an individual's ability to live a lifestyle that is compatible with the individual's interest and abilities
    - Modification or improvement of functional skills
    - Guidance and direction for social/emotional support
    - Facilitation of both the physical and social integration of an individual into typical family routines and rhythms

Applied Behavior Analysis Services

Applied Behavior Analysis Services (ABA) means a therapy service that is a highly intensive, individualized instruction and behavior intervention to assist an individual in developing skills with social value. Applied Behavior Analysis is provided over two (2) to three (3) year time period and is provided to individuals between the ages of two (2) and seven (7)

Unit of Service

¼ hour (15 minutes)

A key component of Applied Behavior Analysis is "discrete trial therapy" which seeks to use empirically validated behavior change procedures for assisting individuals in developing skills with social value. The primary goals of ABA are to lessen behavioral excesses such as tantrum and acting out behaviors and to improve communication skills

Activities Allowed

Reimbursement for Applied Behavior Analysis Services includes the following activities:

- Preparing the applied behavior support plan in accordance with 460 IAC 6-18-1
- Discrete trial therapy consisting of
  - Antecedent: a directive or request for the individual to perform an action;
  - Behavior: a response from the individual, including anything from successful performance, non-compliance, or no response;
  - Consequence: a reaction from the therapist, including a range of responses from strong positive reinforcement, faint praise, or a negative (not aversive) reaction; and
  - Intertrial Interval: a pause to separate trials from each other
- Provide a minimum of 4 to 6 hours of services 5 – 7 days a week for a for a period of 2 – 3 years
- Skills that are prerequisites to language are heavily emphasized (attention, cooperation, imitation)
- Provide for one-on-one structured therapy
- Specific program must include:

- Attending skills (to therapist, adults and peers);
- Imitation skills (motor and verbal);
- Receptive and expressive language skills development;
- Appropriate toy play; and
- Appropriate social interaction

- Family training so that skills can be generalized and communication promoted

- Emphasize the acquisition of new behaviors

- Close monitoring of therapy, with detailed data collection

Activities Not Allowed

Reimbursement is not available through Applied Behavior Analysis Services in the following circumstances:

- Aversive techniques

- Applied behavior analysis for an individual older than 7 years

Service Standards

Applied Behavior Analysis Services must be reflected in the Individualized Support Plan

- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan

- Services must be detailed in the applied behavior support plan

- Services are usually one-to-one, with the exception of time spent in family training

- **Chemical restraints and medications prescribed for use as needed (PRN) meant to retrain the individual shall be used with <u>caution</u>**. The use of these medications must be approved by the person centered planning team and the appropriate human rights committee

- The efficacy of the plan must be reviewed regularly and adjusted as necessary

- **The behavior specialist will provide a written**

report to pertinent parties <u>at least quarterly</u>. "Pertinent parties" includes the individual, guardian, BDDS service coordinator, waiver case manager, all service providers, and other entities

Provider Qualifications

To be approved to provide Applied Behavior Analysis Services as a lead therapist, an applicant shall meet the following requirements:

- (1) Either be a licensed:
  - (A) Psychiatrist under IC 25-22.5; or
  - (B) Psychologist under IC 25-33 and have an endorsement as a health service provider in psychology pursuant to IC 25-33-1-5.1 (c)
- (2) Meet all of the following requirements:
  - (A) Have completed at least one thousand five hundred (1,500) hours of training or supervised experience in the application of applied behavior analysis or an equivalent behavior modification theory for children with a pervasive developmental disorder.
  - (B) Have at least (2) years of experience as an independent practitioner as a supervisor of less experienced clinicians

To be approved to provide Applied Behavior Analysis Services as a <u>senior therapist</u>, an applicant shall either:

- (1) Be a psychotherapist; or
- (2) Meet the following requirements:
  - (A) Have completed at least 3,000 hours of training or supervised experience in the application of applied behavior analysis or an equivalent behavior modification theory for children with a pervasive developmental disorder
  - (B) Have at least four hundred (400) hours of training or supervised experience in the use of applied behavior analysis or an equivalent behavior modification program for children with an autistic disorder, Asperger's disorder, or pervasive developmental disorder which may be included in the three thousand (3,000) hour training requirement in clause (A)

To be approved to provide Applied Behavior Analysis Services as line staff, an applicant must either:

- (1) be in at least the second year of college and have obtained at least thirty (30) hours of

experience utilizing intensive behavioral treatment with children with autism or at least one hundred sixty (160) hours working in any setting with children with autism; or
- (2) be at least eighteen (18) years of age, a high school graduate, and have received at least two thousand (2,000) hours of training or supervised experience in the application of applied behavior analysis or an equivalent behavior modification program in a setting working with children with autism

To maintain approval as a senior therapist, a senior therapist shall obtain annually at least ten (10) continuing education hours related to applied behavior analysis:
- (1) from a Category I sponsor as provided in 868 IAC 1.1-15; or
- (2) as provided by the BDDS's applied behavior analysis support curriculum list

For an entity to be approved to provide Applied Behavior Analysis Services, the entity shall certify that if approved, the entity shall provide lead therapist services, senior therapist services, or line staff services using only persons who meet the qualifications set out in 460 IAC 6-5-32

Beginning July 1, 2004, a provider of Applied Behavior Analysis Services who:
- (1) prepares an applied behavior analysis support plan; or
- (2) implements an applied behavior analysis support plan;

shall cooperate with the division's or the BDDS's regional human rights committee for the geographic area in which the provider is providing services under 460 IAC 6

Documentation Standards

Applied Behavior Analysis Services documentation must include:

- Services outlined in Individualized Support Plan
- Details outlined in the applied behavior analysis support plan
- Records documenting the date and time of service and the number of units of service delivered that day and service type (behavior plan review; family training; individual intervention)

- Documentation that supports compliance with staffing ratios per the individual's service planner
- Documentation in compliance with 460 IAC 6-18-4
- Monthly report of behavioral progress

Behavioral Support Services

Behavioral Support Services means training, supervision, or assistance in appropriate expression of emotions and desires, compliance, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors

Unit of Service

Level 1 Clinician - monthly rate based on the needs of the individual

Level 2 Clinician – monthly rate based on the needs of the individual

Activities Allowed

Reimbursable activities of Behavioral Support Services include:

- Observation of the individual and environment for purposes of development of a plan and to determine baseline
- Development of a behavioral support plan
- Obtain consensus of the Individualized Support Team that the behavioral support plan is feasible for implementation
- Training in assertiveness
- Training in stress reduction techniques
- Training in the acquisition of socially accepted behaviors
- Training staff, family members, roommates, and other appropriate individuals on the implementation of the behavioral support plan
- Consultation with team members
- Consultation with HSPP

Activities Not Allowed

The following activities are not allowed under Behavioral Support Services:

- Aversive techniques
- Any techniques not approved by the individual's person centered planning team and the provider's human rights committee
- In the event that a Level 1 clinician performs Level 2 clinician activities, billing for Level 1 services is not allowed. In this situation, billing for level 2 services is only allowed

Service Standards

Behavioral Support Services must be recognized as needed and appropriate in the Individualized Support Plan (ISP)

- Services must address needs identified in the person centered planning process and be outlined in the ISP
- The behavior supports specialist will observe the individual in his/her own milieu and develop a specific plan to address identified issues
- The behavior supports specialist must assure that Residential Habilitation and Supports direct service staff are aware of and are active participants in the development and implementation of the Behavior Support Plan
- The behavior plan will meet the requirements stated in 460 IAC 6-18-2
- The behavior supports provider will comply with all specific standards in 460 IAC 6-18
- Any behavior supports techniques that limit the individual's human or civil rights must be approved by the person centered planning team and the provider's human rights committee. **No aversive techniques may be used**
- **Chemical restraints and medications prescribed for use as needed (PRN) meant to retrain the individual shall be used with caution**. The use of these medications must be approved by Individualized Support Team (IST) and the appropriate human rights committee

- The efficacy of the plan must be reviewed not less than quarterly and adjusted as necessary

- **The behavior specialist will provide a written report to pertinent parties at least quarterly**. "Pertinent parties" includes the individual, guardian, BDDS service coordinator, waiver case manager, all service providers, and other involved entities

Provider Qualifications

To be approved to provide Behavioral Support Services as a licensed **Level 1 clinician**:

- An applicant shall be a licensed psychologist under IC 25-33 and have an endorsement as a health service provider in psychology pursuant to IC 25-33-1-5.1(c).

To be approved to provide Behavioral Support Services as a licensed **Level 2 clinician**:

(1) Have:

(A) have a master's degree in:

(i) a psychology;

(ii) special education; or

(iii) social work; and

(B) meet all of the following requirements:

- (i) Have a bachelor's degree
- (ii) Be employed as a behavioral consultant on or before September 30, 2001, by a provider of behavioral support services approved under 460 IAC 6
- (iii) Be working on a master's degree in psychology, special education or social work
- (iv) By December 31, 2006 complete a master's degree in psychology, special education or social work

(2) Be supervised by a Level 1 clinician.

To maintain approval as a behavioral support services provider, a behavioral support services provider shall:

- (1) Obtain annually at least ten (10) continuing education hours related to the practice of behavioral support:
- (A) From a Category I sponsor as provided in 868 IAC 1.1-5;
- (B) As provided by the BDDS's behavioral support curriculum list; or

(2) be enrolled in:

- a master's level program in clinical psychology, counseling psychology, school psychology, or another applied health services area of psychology, or special education, or social work; or
- a doctoral program in psychology

For an entity to be approved to provide behavioral support services, the entity shall certify that, if approved, the entity shall provide Level 1 clinician behavioral support services or Level 2 clinician behavioral support services using only persons who meet the qualifications set out in 460 IAC 6-5-4

Beginning July 1, 2004, a provider of Behavioral Support Services who:

- (1) prepare a behavioral support plan; or
- (2) implements a behavioral support plan; shall cooperate with the division's or the BDDS's regional human rights committee for the geographic area in which the provider is providing services under 460 IAC 6

Documentation Standards

Behavioral Support Services documentation must include:

Level 1 Clinician

- Services outlined in ISP
- Behavioral Support Plan
- Data record documenting the service performed, i.e., diagnosis; behavior plan review; staff training; individual intervention; consultation with Level 2 Clinician, etc.
- Documentation in compliance with 460 IAC 6

- This documentation will be reviewed as part of the BQIS quality reviews. Failure to maintain these monthly summaries as described above will be considered a violation of the Medicaid provider agreement and reimbursement for services will not be available

Level 2 Clinician

- Services outlined in ISP
- Behavioral Support Plan signed by Level 1 clinician
- Data record of documenting the service performed, i.e., behavior plan writing/editing; staff training; individual intervention; consultation with HSPP, etc.
- Monthly report by QMRP or Behavior Specialist of behavioral progress
- Documentation in compliance with 460 IAC 6
- This documentation will be reviewed as part of the BQIS quality reviews. Failure to maintain these monthly summaries as described above will be considered a violation of the Medicaid provider

Case Management Services

Case Management Services means services that enable an individual to receive a full range of appropriate services in a planned, coordinated, efficient, and effective manner

Unit of Service

Monthly rate for the provision of Annual Level of Care determination and re-determination

Monthly rate for the provision of ongoing services

Activities Allowed

Case Management activities include:

- Monitoring of services as outlined in 460 IAC 6-19-6
- Face-to-face contacts between the case manager and individual as required by 460 IAC 6-19-6(g) and (h)
- Developing, updating, and reviewing Individualized Support Plan (ISP) using Person Centered Planning Process

- Completing and processing annual Level of Care
- Developing annual Cost Comparison Budgets using State approved process
- Disseminating information and forms to the individual and the Individualized Support Team (IST)
- Incident report completion, submission and follow-up
- Monitoring of service delivery and utilization via telephone calls, home visits and team meetings
- Monitoring consumer satisfaction and service outcomes
- File maintenance
- Acting as an agent for the individual to assure the interests and preferences of the individual are represented across all environments; and strengthening informal and natural supports for each individual
- The negotiation of the best solutions for resource identification and other individual or system needs

Activities Not Allowed

Reimbursement is not available through Case Management Services including but not limited to, the following situations:

- Services delivered to an individual who does not meet eligibility requirements established by BDDS
- Counseling services related to legal issues. Such issues shall be directed to the Indiana Advocacy Services, the designated Protection and Advocacy agency under the Developmental Disabilities Act and Bill of Rights Act, P.L. 100-146
- A person related through blood or marriage to any degree to an individual may not conduct case management for that individual

Service Standards

Case Management Services shall be reflected in the ISP

- Provision of services must comply with 460 IAC 6-19

- Case Management Services must be included as a service in the ISP and in the Cost Comparison Budget (CCB)

Provider Qualifications

To be approved to provide Case Management Services as a **Level 1 Case Management Services Provider,** an applicant shall meet the following requirements:

- (1) Have a bachelor's degree, be a registered nurse licensed under IC 25-23-1, or be employed by the State in a PAT III position
- (2) Meet the experience requirements for qualified mental retardation professional in 42 CFR 483.430(a)
- (3) Complete a course of Case Management Orientation that is approved by DDRS
- Have not been de-certified by the State
- Must be in good standing with the State

To be approved to provide Case Management Services as a **Level 2 Case Management Services Provider,** an applicant shall meet the following requirements**:**

- (1) Have at least a four year college degree with no direct care experience; or
- (2) Have a high school diploma, or equivalent, and have at least five (5) years experience working with persons with mental retardation or other developmental disabilities; and
- (3) Be supervised by a Level 1 Case Management Services Provider who is supervising no more than four (4) other Level 2 Case Management Services Providers
- (4) Complete a course of Case Management Orientation that is approved by the DDRS
- Have not been de-certified with the State
- Must be in good standing with the State

For an entity to be approved to provide Case Management services, the entity shall:

- Certify that, if approved, the entity will provide Case management services using only persons who meet the qualifications set out in 460 IAC 6-

Documentation Standards

Case Management Services documentation includes:

Documentation for Billing:

- Approved provider
- Must provide documentation identifying them as the case manager of record for the individual (the pick list is appropriate documentation)

Clinical/Progress Documentation:

- Documentation in compliance with 460 IAC 6-19
- Documentation must be entered into the electronic data system within seven (7) days of the provision of services

Audit Criteria for Case Management

Children's Foster Care Services

Children's foster care services means a living arrangement in which an individual under the age of eighteen (18) lives in the private home of a principal caregiver who is **unrelated** to the individual and has no legal responsibility to support the individual. **BDDS will only approve a foster placement for a child in unusual circumstances and only if the child cannot receive foster placement through the FSSA Office of the Division of Family and Children or services via the Department of Education.** Necessary support services are provided by the principal caregiver as part of children's foster care

Separate payment will not be made for homemaker or chore services furnished to an individual receiving children's foster care, since these services are integral to and inherent in the provision of children's foster care services.

The total number of individuals living in the home who are unrelated to the caregiver may not exceed three (3).

This service is only reimbursable through state funded services (not available through Medicaid Waiver services)

Unit of Service

1 day of services

Rates

There are three levels of rates. The Individualized Support Team (IST) determines what level of supports are required for the individual, based on what services an individual would utilize if foster care services were not available

A Service Planner must be completed showing the services and amounts of services required in another setting. This will help demonstrate the cost effectiveness of the individual receiving Children's Foster Care services. If there are changes in the individual's condition that may call for a change in the level of service, the IST will redetermine what level of supports the individual requires, with ultimate approval given according to who can approve a specific level of service

Level 1 - Approved by Service Coordinator
Level 2 - Approved by District Mgr.
Level 3 - Approved by Central Office

Issues to consider in determining which tier of services the individual receives include the amount of time the foster family will need to spend in 1) health and safety management; 2) challenges and experiences aimed at increasing a person's ability to live a lifestyle that is compatible with the person's interest and abilities; 3) modification or improvement of functional skills; 4) guidance and direction for social/emotional support; and 5) facilitation of both the physical and social integration of a person into typical family routines and rhythms

Activities Allowed

Reimbursable activities under children's foster care services include, but are not limited to, the following:

- Personal care and services
- Homemaker/chore services
- Attendant care and companion care services
- Medication oversight
- Respite for the foster parent (funding for this is included in the per diem paid to the service provider)

- Other appropriate supports as described in the Individualized Support Plan

Activities Not Allowed

Activities that are not reimbursable through Children's Foster Care Services include:

- Residential Living Allowance and Management Services are not available to individuals receiving Children's Foster Care
- Children's Foster Care Services provided in the home of a caregiver who is related by blood or marriage, in any degree, to the individual are not allowed
- Payment for room and board is not available to individuals receiving Children's Foster Care (Social Security Benefits should be used to pay for room and board as well as for personal needs) ($80.00/month or as reflected in the ICLB Guidelines Policy)

Service Standards

Children's Foster Care Services must be reflected in the Individualized Support Plan

- Services must address needs (i.e. developmental needs, vocational needs, etc.) identified in the person centered planning process and be outlined in the Individualized Support Plan
- Other services such as Community Habilitation and Participation Services, Transportation, etc. may be added to the individual's Cost Comparison Budget or ICLB; however, reimbursement would be through those services, not through Children's Foster Care Services
- 10% of the total per diem amount is intended for use by the provider for respite care as needed. It is the provider's responsibility to approve any providers of respite chosen by the family
- The provider determines the total amount per month paid to the foster parent
- The agency's administrative/supervision fee comes from the remaining total amount and includes the following duties:
    a. Publish written policies and procedures

regarding foster parent support services
b. Maintain financial and service records to document services provided to the individual
c. Establish a criteria for the acceptance of the foster parent, screen potential foster parents for qualities of stability, maturity, and experiences so as to ensure the safety and well being of the individual, and obtain a criminal background and reference check
d. Coordinate/provide adequate initial training and ongoing training, consultation and supervision to the foster parent
e. Provide for the safety and well being of the individual by inspection of environment for compliance with DDRS policies, and procedures, including, but not limited to, the provider and case management standards found in 460 IA 6
f. Reimburse foster parent

Provider Qualifications

To be approved to provide Children's Foster Care Services, an applicant shall:

- Be an entity approved to provide supported living services under 460 IAC 6; and
- Certify that, if approved, the provider shall employ only those individuals who meet the qualifications set out in 460 IAC 6-14-5

Documentation Standards

Children's Foster Care Services documentation includes:

- Services outlined in Individualized Support Plan

Documentation by Providers:

- Written policies and procedures, including for screening and accepting foster parents
- Maintain financial and service records to document services provided to the individual
- Document provision of training to foster parents according to agency policies/procedures
- Reimbursement of foster parent

Families:

- One entry per day detailing an issue concerning the individual
- Entry should detail any goal-oriented activities, tying those into measurable progress toward the individual's goal (as identified in the ISP)
- The entry should also include any significant issues concerning the individual, including:
    - Health and safety management
    - Developmental challenges and experiences aimed at increasing an individual's ability to live a lifestyle that is compatible with the individual's interest and abilities
    - Modification or improvement of functional skills
    - Guidance and direction for social/emotional support
    - Facilitation of both the physical and social integration of an individual into typical family routines and rhythms

Community-Based Sheltered Employment Services*	Community-Based Sheltered Employment Services means an agency-operated, work-oriented service consisting of on-going supervision of an individual while the individual is working This service is only reimbursable through state funded services (not available through Medicaid Waiver services)
Unit of Service	1 hour
Activities Allowed	Reimbursement is available for Community-Based Sheltered Employment Services, including, but not limited to: • Adaptations, training, supervision and support activities required by the individual and needed to develop work skills • Mobile work crews and enclaves • Janitorial and landscaping work • Temporary or permanent work crews off-site

- Services are delivered in response to the individual's needs and interests and the person-centered service plan
- Though services are delivered in a small group, only face-to-face services are reimbursable

Activities Not Allowed

Reimbursement is not available through this service for the following activities, including:

- Meal time (**Note**: Lunchtime and breaks may be billed as group habilitation (CHPR) **if** the individual is receiving supervision or assistance during those times.)
- Transportation Services (Transportation costs may be billed under Transportation Services – Title XX or under waiver transportation services)
- Ancillary services

Service Standards

All Community-Based Sheltered Employment Services must be reflected in the individual's service plan

- Services are tailored to the identified need of the individual per the individual's person centered planning process and Individualized Support Plan
- Services will include remunerative employment or other employment training services
- Individual to staff ratio shall not exceed 8 individuals to1 staff member per 460 IAC 6-20-1
- Two short break periods (up to 15 minutes in the morning and the afternoon) may be included
- Services cannot take place in a segregated setting that is owned or leased by the provider agency **Only integrated settings are eligible for Community-Based Sheltered Employment Services**. IAC 460 6-20-2. (See definition, page 42)

Provider Qualifications

To be approved to provide Community-based Sheltered Employment Services, an applicant shall meet the following requirements:

- (1) Be an entity
- (2) Be accredited by one (1) of the following organizations:
    - (A) Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor;
    - (B) The Council on Quality and Leadership in Supports for People with Disabilities, or its successor;
    - (C) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor;
    - (D) The National Commission on Quality Assurance, or its successor; or
    - (E) An independent national accreditation organization approved by Secretary of FSSA
- (4) Certify that, if approved, the entity will provide Community-Based Sheltered Employment Services using only persons who meet the qualifications set out in 460 IAC 6-14-5
- (5) Not be a community mental health center

Documentation Standards

Community-Based Sheltered Employment documentation must include:

- Not-for-Profit status
- BDDS approved provider
- Services outlined in Individualized Support Plan
- Attendance record documenting the date and time of service and the number of units of service delivered that day.
- Documentation that supports compliance with staffing ratios per the individual's service planner
- Documentation in compliance with 460 IAC 6

Note – An individual who is receiving waiver services may have the choice to also receive Community-Based Sheltered Employment Services via Title XX funding

DEFINITION: Integrated setting:
Integrated setting means a setting in which at least fifty-one percent (51%) of the persons working in the setting are not disabled, except for the persons providing services under this article. 460 IAC 6-3-33.

*** Under 460 IAC 3.5 (Rates for Adult Day Services) Community- Based Sheltered Employment Services are defined as "*Community-Based Sheltered Work*"**

Community Transition Supports	Community Transition Supports means supports that are **<u>one-time</u>** set-up expenses for individuals who are transitioning from an institution to a supported living setting in the community Items purchased through Community Transition Supports are the property of the individual receiving the service, and the individual will take the property with him/her in the event of a move to another residence, even if the residence from which he/she is moving is owned by the provider agency
Unit of Service	Actual cost reimbursement up to $1,000
Allowable Activities	Reimbursement for Community Transition Supports may include all or some of the following: • Community Transition Supports is available when an individual will be moving into his/her own home. "Own home" is defined as any dwelling, including a house, apartment, condominium, trailer, or other lodging that is owned, leased, or rented by the individual and/or the individual's guardian or family, or a home that is owned and/operated by the agency providing supports • Security deposits that are required to obtain a lease on an apartment or home • Essential furnishings and moving expenses required to occupy and use a community domicile, including a bed, table/chairs, window coverings, eating utensils, food preparation items, bed/bath lines, etc.; • Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; and • Health and safety assurances including pest eradication, allergen control or one-time cleaning prior to occupancy • When the individual will be receiving state line item residential services as authorized within the Individual Community Living Budget (ICLB), the

Community Transition Supports service is included in the ICLB

- When the individual is receiving residential habilitation and support services within the Medicaid DD or Autism Waiver, the Community Transition Supports service is included in the Cost Comparison Budget

Activities Not Allowed

Reimbursement for Community Transition Supports is not available in the following circumstances:

- Monthly rental expenses for apartment/housing, cable TV, etc., are not covered
- Appliances, television, VCRs, or diversional/recreational items such as hobby supplies are not covered
- Food expenses are not covered
- No expenses related to a subsequent move to another community living arrangement are covered
- An individual residing within the home of his/her family or guardian, or within a facility based service, is not eligible for Community Transition Supports

Service Standards

Community Transition Supports should be reflected in the Individualized Support Plan of the individual

- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan

Provider Qualifications

To be approved to provide Community Transition Supports, and applicant shall:

- Be approved to provide Residential Living Allowance and Management Services
- Certify that, if approved, the entity will provide Community Transition Supports utilizing only qualified entities. (Pest control entities must be licenses under IC 15-3-3.6 and licensure will be verified locally by the planning team or the residential provider.)

Documentation Standards	Community Transition Supports documentation requirements include: • Maintain receipts for all expenditures, showing the amount and what item or deposit was covered
Crisis Assistance Services	Crisis Assistance Services means services designed to provide immediate access to short-term, intensive services that are needed due to a behavior or psychiatric emergency Crisis Assistance Services will be provided in a safe, therapeutic environment that is the least restrictive setting possible - the individual's home environment, whenever possible. When temporary placement outside the individual's current environment is necessary because the individual poses a health/safety threat to him/herself, to housemates or to others, Crisis Assistance Services will be delivered in an out-of-home setting approved by BDDS. Crisis Assistance Services will include behavior interventions, behavior modification planning and services (above and beyond "traditional" behavior modification), developing and implementing an Individualized Support Plan, training staff to implement the behavior plan, and other supportive services. The individual's usual caregivers and service providers will continue to furnish other services during the crisis period when the service is delivered in the individual's home Only those services not otherwise reimbursable through Medicaid or Medicaid Waivers **and authorized by BDDS in advance** will be paid by BDDS
Unit of Service	Daily rate - negotiated with DDRS
Activities Allowed	Reimbursement is available for Crisis Assistance Services for the following activities: • Behavior intervention specifically to resolve a behavioral crisis • Behavior modification programming and services necessary to resolve the crisis • Develop and implement an individualized person

centered program and support plan

- Train direct care staff to implement plans
- Work collaboratively with other providers to minimize reoccurrence of behavior or psychiatric emergencies
- Work collaboratively with other providers to ensure individual's smooth transition back to home environment, when a crisis has required an out-of-home placement
- Crisis Assistance Services should be delivered in the individual's home setting; OR
- Crisis Assistance Services may be delivered in an out-of-home placement for the individual when there is a threat to the safety/wellbeing of the individual, housemates, staff, or other individuals

Activities Not Allowed

Reimbursement is not available under Crisis Assistance Services for activities including:

- Service delivered when an individual is not in a behavioral or psychiatric crisis;
- Out-of-home placements without BDDS approval **prior to placement**.

Service Standards

Crisis Assistance Services must be based on a person centered Individualized Support Plan for the individual

- Providers will follow DDRS provider standards (460 IAC 6)
- Providers shall employ qualified, trained individuals
- Services will be individually tailored, based on the needs of the individual in crisis

Provider Qualifications

To be approved to provide crisis assistance services, an applicant shall:

- Be approved to provide behavioral support services under 460 IAC 6

Documentation Standards	Crisis Assistance Services documentation must include: • Documentation that services are individually tailored, based on the needs of the individual in crisis • Data record of staff to individual service documenting the date and time of the service and the number of units of service delivered that day • Each staff member provides at least one entry on each day of service, describing an issue concerning the individual. The entry shall include time and date of entry and at least the last name and first initial of the staff person making the entry. The entry shall be done by staff person providing the direct service. Any significant issues involving the individual shall be documented • At least weekly documentation regarding individual progress, including any treatment related interaction with psychiatrists, physicians and other providers • Documentation that supports compliance with staffing ratios per the individual's service planner • Documentation in compliance with 460 IAC 6

Day Services

Day Services means services outside of an individual's home that support, in general, learning and assistance in any of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living, including development of employment skills. These activities are directly related to the Individualized Support Plan (ISP). Each individual receiving Day Services works toward acquiring the skills to become an active member of the community. The continuum of services within Day Services provides opportunities in facility based and the community based services to become more independent and more integrated within community activities.

Day Services can be delivered to an individual one-on-one or in a group setting and in the community, work setting, or facility.

Unit of Service

Daily rate based on the needs of the individual

Activities Allowed

Direct supervision, monitoring, training, education, demonstration or support to assist with

- An individual's personal needs (feeding, toileting, etc.)
- Transportation (excluding transportation that is covered under the Medicaid State Plan)
- Acquisition, improvement and retention of daily living skills
- Training and learning in the areas of employment skills, educational opportunities, hobbies and leisure activities
- Development of self-advocacy skills, acquiring skills that enable an individual to exercise control and responsibility over services and supports received or needed
- Activities that are directly related to the outcomes outlined in the Individualized Service Plan (ISP)

Activities Not Allowed

Day Services does not include the following situations:

- Services furnished to a minor by the parent(s), step-parent(s) or legal guardian

- Services furnished to an individual by the person's spouse
- Any service that is otherwise available under the Rehabilitation Act of 1973 or Public Law 94-124
- Services that are available under the Medicaid State Plan

Service Standards

Day Services must be reflected in the Individualized Support Plan (ISP)

- Services must address needs identified in the person centered planning process and be outlined in the ISP

Provider Qualifications

To be approved to provide Day Services, an applicant shall:

- Meet the requirements for direct care staff set out in 460 IAC 6-14-5 and 6-5-30
- An entity shall certify that, if approved, the entity will provide Day Services using only persons who meet the qualifications set out in 460 IAC 6-14-5

If providing an employment service an applicant shall also:

(1) Be accredited by, or provide proof of an application to seek accreditation from, one of the following organizations:

(A) Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor;

(B) The Council on Quality and Leadership in Supports for People with Disabilities, or its successor;

(C) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor;

(D) The National Commission on Quality Assurance, or its successor; or

(E) An independent national accreditation organization approved by the Secretary of FSSA

Documentation Standards	Day Services documentation must include: Documentation for Billing: • Approved provider • The provider must use the approved participant attendance record. Each entry must include the initials of the individual who completes the daily entry. The provider maintains a list of staff who complete the form listing staff name and initials used. Clinical/Progress Documentation: • The provider completes a monthly summary of the individual's progress towards outcomes, using the approved form. This is a narrative summary, about one page in length, that describes the individual's day service activities, and must address outcomes in the individual's ISP, as well as a high level summary of issues affecting the health, safety and welfare of the individual requiring intervention by a healthcare professional, case manager, behavior support services provider or BDDS staff member. • This documentation will be reviewed as part of the BQIS quality reviews. Failure to maintain these monthly summaries as described above will be considered a violation of the Medicaid provider agreement and reimbursement for services will not be available.
Environmental Modification Supports	Environmental Modification Supports means a physical adaptation to an individual's home to (1) ensure the health, welfare and safety of the individual; or (2) enable the individual to function with greater independence in the individual's home; (3) without which the individual would require institutionalization **BDDS must authorize any modifications or adaptations prior to the service being delivered**
Unit of Service	Unit for Assessments: ¼ hour (15 minutes) Unit for Modifications - Install: 1 job Unit for Maintenance: 1 job

Reimbursement for Environmental Modification Supports has a lifetime cap of $15,000 with an annual $500 limit for maintenance and repairs

Activities Allowed

The following activities are included in Environmental Modification Supports (which require prior approval by BDDS):

- Installation of ramps and grab bars
- Widening doorways
- Modifying bathroom facilities
- Installation of specialized electric and plumbing systems necessary for the welfare of the individual
- Other appropriate modifications
- Modifications costing more than $500 require an assessment by a qualified professional (house contractor, architect, physician, nurse, occupational therapist, speech/language therapist, physical therapist, or rehabilitation engineer), so the cost of the assessment is covered
- Maintenance and repair of the items and modifications installed during the initial request
- Anti-scald devices

Activities Not Allowed

Reimbursement is not available for Environmental Modification Supports in these circumstances:

- Adaptations and improvements that are not of direct medical or remedial benefit to the individual

  (i.e., carpeting, roof repair, central air conditioning, etc.)

- Adaptations and improvements that add to the total square footage of the home
- Cost of adaptations and improvements exceeding the $15,000 lifetime cap

Service Standards

Environmental Modification Supports should be reflected in the Individualized Support Plan

- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan
- $15,000 lifetime cap, with annual $500 limit for maintenance and repairs
- Modifications must be of direct medical or remedial benefit to the individual

Provider Qualifications

To be approved to provide Environmental Modification Supports, an applicant shall:

- (1) Be licensed, certified, registered, or otherwise properly qualified under federal, state, or local laws applicable to the particular service that the applicant desires to perform; and
- (2) Certify that, if approved, the applicant will perform the services in compliance with federal, state, or local laws applicable to the type of modification being made

Documentation Standards

Environmental Modifications Supports documentation must include:

- Documentation of time spent providing assessment and report with recommendations from assessment
- Identified need in Individualized Support Plan
- Identified direct medical benefit for the individual
- At least 3 bids for the service, or documentation why 3 bids were not available
- Documentation of completed and approved work
- Documentation in compliance with 460 IAC 6

Facility-Based Sheltered Employment Services*	Facility-Based Sheltered Employment Services means employment services provided to an individual that implement the individual's training outcomes and in which the individual is provided remuneration or other occupational activity This service is only available through state funded services (not available through Medicaid Waiver services)
Unit of Service	1 hour
Activities Allowed	Reimbursement is available for Facility-Based Sheltered Employment Services activities including: • May be short term or long term, full time or part time • Adaptations, training, and supervision activities required by the individual and needed to sustain paid employment or other occupational activity • All activities are goal directed • Services are provided, depending on the identified needs of the individual • Total amount of time individuals served by each agency participate in Facility-Based Sheltered Employment Services are expected to decrease and time spent in community-based employment to increase
Activities Not Allowed	Reimbursement is not available for Facility-Based Sheltered Employment Services activities including: • Meal time (**Note**: Lunchtime and breaks may be billed as group habilitation (CHPR) **if** the individual is receiving supervision or assistance during those times.) • Transportation (See Title XX Transportation.) • Ancillary services
Service Standards	Facility-Based Sheltered Employment Services must be reflected in the Individualized Support Plan. **That**

plan shall include a justification of why a more inclusive alternative is not being utilized and/or a plan to move the individual to a more inclusive setting

- Individuals typically receive thirty (30) hours per week of this service; however, services are tailored to the identified needs of the individual per the individual's person centered planning process and Individualized Support Plan
- Recipient to staff ratio shall not exceed 20:1
- Two short break periods (up to 15 minutes in the morning and the afternoon) may be included

Provider Qualifications

To be approved to provide Facility-Based Sheltered Employment Services, an applicant shall:

- (1) Be an entity
- (2) Be accredited, or provide proof of an application to seek accreditation, by one (1) of the following organizations:
    - (A) Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor;
    - (B) The Council on Quality and Leadership in Supports for People with Disabilities, or its successor;
    - (C) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor;
    - (D) The National Commission on Quality Assurance, or its successor; or
    - (E) An independent national accreditation organization approved by Secretary of FSSA
- (3) Be a not-for-profit entity
- (4) Have a Sheltered Workshop Certification from the Wage and Hour Division of the U.S. Department of Labor

- (5) Certify that, if approved, the entity will provide services using only persons who meet the qualifications set out in 460 IAC 6-14-5

Documentation Standards

Facility-Based Sheltered Employment documentation must include:

- Not-for-profit status
- BDDS approved provider
- Sheltered Workshop Certification
- Services outlined in Individualized Support Plan
- Attendance record documenting the complete date and time entry (including a.m. or p.m.) and the number of units of service delivered that day
- Documentation that supports compliance with staffing ratios per the individual's service planner
- Documentation in compliance with 460 IAC 6

***Under 460 IAC 3.5 (Rates for Adult Day Services) Facility-Based Sheltered Employment Services is defined as "*Sheltered Work*"**

Family and Caregiver Training Services

Family and Caregiver Training Services provides training and education (1) to instruct a parent, other family member, or primary caregiver about the treatment regimens and use of equipment specified in the Individualized Support Plan; and (2) to improve the ability of the parent, family member or primary caregiver to provide the care to or for the individual

Activities Allowed

Reimbursement is available through Family and Caregiver Training Services for instruction in

- Treatment regimens and use of equipment
- Stress management
- Parenting
- Family dynamics
- Community integration
- Behavioral intervention strategies
- Mental health

- Caring for medically fragile individuals

Activities Not Allowed	Reimbursement is not allowed through Family and Caregiver Training Services in the following circumstances: • Training/instruction not pertinent to the caregiver's ability to give care to the individual • Training provided to caregivers who receive reimbursement for training costs within their Medicaid or state line item reimbursement rates • Meals, accommodations, etc., while attending the training
Service Standards	Family and Caregiver Training Services must be included in the Individualized Support Plan • The Individualized Support Plan shall be based on the person centered planning process with that individual • Funds are limited to no more than $2,000/year
Provider Qualifications	To be approved to provide Family and Caregiver Training Services, an applicant shall be approved to provide either: • (1) Community Habilitation and Participation Services; or • (2) Residential Habilitation and Support Services under 460 IAC 6
Documentation Standards	Family and Caregiver Training Services documentation must include: • Services outlined in the Individualized Support Plan • Receipt of payment for activity • Proof of participation in activity if payment is made directly to individual/family. • Documentation in compliance with 460 IAC 6

Health Care Coordination Services	Health Care Coordination Services means medical coordination services to manage the health care needs of the individual **This service is a component of Residential Habilitation and Support Services**
Units of Service	The number of units an individual receives is based on the needs of that individual, but the individual is limited to no more than 4 Units of Health Care Coordination Services per month. **The appropriate level should be determined by a healthcare professional (LPN, RN, or physician)** 1 Unit = health care needs require at least weekly* consultation/review with RN/LPN including face to face visits once a month 2 Units = health care needs require at least weekly* consultation/review with RN/LPN including face to face visits at least twice a month 3 Units = health care needs require at least twice weekly* consultation/review with RN/LPN including face to face visits once a week 4 Units = health care needs require at least twice weekly* consultation/review with RN/LPN including face to face visits at least twice a week * weekly – a calendar week (Sunday – Saturday)
Activities Allowed	Reimbursement is available for Health Care Coordination Services in the following circumstances: • The individual requires assistance in coordinating medical needs beyond what can be provided in routine doctor/health care visits • Health Care Coordination Services are specifically included in the individual's support plan • The RN/LPN provider coordinates health services including, but not limited to - Physician consults - Medication ordering

- Development and oversight of a health care support plan
- Consultations with the individual as described in the support plan
- Consultations with guardian and or health care representative as applicable
- Face to face visits with the individual as described in the support plan

Activities Not Allowed

Reimbursement for Health Care Coordination Services is not available under the following circumstances:

- The individual does not require Health Care Coordination Services
- The individual is receiving Skilled Nursing services through the Medicaid State Plan
- Skilled nursing services that are available under the Medicaid State Plan must be paid through the Medicaid State Plan
- Services that are not specified in the Individualized Support Plan
- Case management services provided under a 1915 (b), 1915 (c) or a 1915 (g) case management waiver cannot be billed as Health Care Coordination Services
- Residential, vocational, and/or educational services otherwise provided under other Supported Living services cannot be billed as Health Care Coordination Services

Service Standards

Health Care Coordination Services must be documented in agency files

- Weekly consultations/reviews
- Face to face visits with the individual
- Other activities, as appropriate
- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan

- **The provider of home health care coordination will provide a written report to pertinent parties <u>at least quarterly</u>**. "Pertinent parties" includes the individual, guardian, BDDS service coordinator, waiver case manager, all service providers, and other entities

Provider Qualifications

To be approved to provide Health Care Coordination Services, and applicant shall:

- (a) Be either a registered nurse (RN) or a licensed practical nurse (LPN) under IC 25-23-1
- (b) Certify that the entity, if approved, will provide Health Care Coordination Services using only persons who meet the qualifications set out in 460 IAC 6-5-14

Documentation Standards

Health Care Coordination Services documentation must include:

- Current RN or LPN license for each nurse
- Need for HCC identified in the Individualized Support Plan
- Evidence of a consultation including complete date, time and signature. Consultation may be with other staff, individual, other professionals, as well as health care professionals.
- Evidence of a face-to-face visit with the member, including complete date and signature
- Documentation in compliance with 460 IAC 6

Music Therapy Services

Music Therapy Services means services provided for the systematic application of music in the treatment of the physiological and psychosocial aspects of an individual's disability and focusing on the acquisition of nonmusical skills and behaviors

Unit of Service

¼ hour (15 minutes)

Activities Allowed

The following activities are included in Music Therapy Services:

- Therapy to improve
  - Self-image and body awareness
  - Fine and gross motor skills
  - Auditory perception

- Therapy to increase
  - Communication skills
  - Ability to use energy purposefully
  - Interaction with peers and others
  - Attending behavior
  - Independence and self-direction

- Therapy to reduce maladaptive (stereotypic, compulsive, self-abusive, assaultive, disruptive, perseverative, impulsive) behaviors

- Therapy to enhance emotional expression and adjustment

- Therapy to stimulate creativity and imagination

- The music therapist may provide services directly or may demonstrate techniques to other service personnel or family members

Activities Not Allowed

Reimbursement is not available for Music Therapy Services in these circumstances:

- Specialized equipment needed for the provision of Music Therapy Services should be purchased under "Specialized Medical Equipment and Supplies Supports"

Service Standards

Music Therapy Services should be reflected in the Individualized Support Plan of the individual

- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan

- Services must complement other services the individual receives and enhance increasing health and safety for the individual

Provider Qualifications

To be approved to provide Music Therapy Services, an applicant shall:

- Be certified by the National Association of Music Therapists

- Certify that, if approved, the entity will provide Music Therapy Services using only persons who meet the qualifications set out in 460 IAC 6-5-15

Documentation Standards	Music Therapy Services documentation must include: • Documentation of appropriate assessment by a qualified therapist • Services outlined in Individualized Support Plan • Documentation in compliance with 460 IAC 6 • Appropriate credentials for service provider • Attendance record, therapist logs and/or chart detailing service provided, date and times • Documentation in compliance with 460 IAC 6
Occupational Therapy Services	Occupational Therapy Services means services provided under this article by a licensed occupational therapist
Unit of Service	¼ hour (15 minutes)
Activities Allowed	Occupational Therapy Services, consisting of the full range of activities provided by a registered occupational therapist, may include: • Evaluation and training services in the areas of gross and fine motor function, self-care and sensory and perceptual motor function • Screening • Assessments • Planning and reporting • Direct therapeutic intervention • Design, fabrication, training and assistance with adaptive aids and devices • Consultation or demonstration of techniques with other service providers and family members • Participating on the interdisciplinary team, when appropriate, for the development of the plan
Activities Not Allowed	Reimbursement is not available through individual Occupational Therapy Services for some services, including: • Activities not delivered one-on-one with the

individual

- Activities delivered in a nursing facility
- Activities that are available through the Medicaid State Plan (i.e., a Medicaid State Plan prior authorization denial is required before reimbursement is available through BDDS for this service.)

Service Standards

Individual Occupational Therapy Services must be reflected in the Individualized Support Plan

- The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan

Provider Qualifications

To be approved to provide occupational therapy services as an **occupational therapist**, an applicant shall:

- Be certified as an occupational therapist under IC 25-23.5

To be approved to provide Occupational Therapy Services as an **occupational therapy assistant**, an applicant shall:

- Be certified as occupational therapy assistant under IC 25-23.5-5

To be approved to provide Occupational Therapy Services as an **occupational therapy aide**, an applicant shall:

- Meet he requirements of IC 25-23.5-1-5.5 and 844 IAC 10-6

- For an entity to be approved to provide Occupational Therapy Services, an entity shall certify that, if approved, the entity will provide Occupational Therapy Services using only persons who meet the qualifications set out in 460 IAC 6-5-17

Documentation Standards

Occupational Therapy Services documentation must include:

- Documentation by appropriate assessment by a qualified therapist
- Services outlined in the Individualized Support Plan
- State contracted day service providers must have proof of not-for-profit status
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing service provided, date and times
- Documentation in compliance with 460 IAC 6

Person Centered Planning Facilitation Services

Person Centered Planning Facilitation Services means services that are provided by a provider other than a provider of case management services that guide an individual through the person centered planning process

This service is a component of Case Management Services

Note - For individuals receiving services on the Support Services Waiver, the cost for Person Centered Planning Facilitation Services is not included in the $13,500 Support Services Waiver annual cap

Unit of Service

¼ hour (15 minutes)

Person Centered Planning means a process that:

- allows an individual, the individual's legal representative, if applicable, and any other person chosen by the individual to direct the planning and allocation of resources to meet the individual's live goals;
- achieves understanding of how an individual (a) learns, (b) makes decisions, and (c) is and can be productive;
- discovered what the individual likes and dislikes; and
- empowers an individual and the individual's family to create a life plan and corresponding ISP for the individual that: (a) is based on the individual's preferences, dreams, and needs; (b) encourages and supports the individual's long term hopes and dreams; (c) is supported by a short term plan that is based on reasonable costs, given the individual's support needs; (d) includes individual responsibility; and (e)

	includes a range of supports, including funded, community, and natural supports The Individualized Support Plan or ISP means a plan that establishes supports and strategies intended to accomplish the individual's long term and short term outcomes by accommodating the financial and human resources offered to the individual through paid provider services or volunteer services, or both, as designed and agreed upon by the individual's support team
Limits	3 hours for the initial/ annual 3 hours for ongoing
Activities Allowed	Reimbursement for Person Centered Planning Facilitation Services includes the following activities: • Directing the PCP process to determine the individual's preferences, dreams, and needs • Assisting the individual and family to make decisions regarding meeting the individual's support needs • Recognizing how the individual makes decisions • Understanding and explaining service options and funding possibilities, including services available through community resources or natural supports that do not require funding • Maintaining focus of team to develop a completed Individualized Support Plan, based on the person centered planning process that meets the individual's needs at a reasonable cost • Explaining the individual's responsibilities
Activities Not Allowed	If the individual's Case Manager is chosen as the PCP Facilitator, reimbursement must be made through PCP Facilitation Services. Reimbursement may not be made through case management time • Reimbursement for Person Centered Planning services may not be made with state line item dollars

Service Standards	Person Centered Planning Facilitation Services must be reflected in the Individualized Support Plan of the individual • Must address needs identified in the person centered planning process and result in a completed Individualized Support Plan • Must occur at least annually, but can occur more frequently, as changes occur
Provider Qualifications	To be approved to provide person centered planning facilitation services an applicant shall either: • (1) Be an entity approved to provide supported living services under 460 IAC 6; or • (2) Complete the requirements set out in 460 IAC 7-4-1(c) For an entity to be approved to provide person centered planning facilitation services and entity shall: • Certify that, if approved, the entity will provide person centered planning facilitation services using only person who meet the qualifications set out in 460 IAC 7-4-1(c)
Documentation Standards	Person Centered Planning Facilitation Services documentation must include: • Original tools used in PCP process (i.e., maps, PATH, etc.) • Notes of discussion, final decisions and the completed ISP • Record of time spent, individuals in attendance, and other relevant information

Personal Emergency Response System Supports (PERS)	Personal emergency response system supports means an electronic communication device that allows an individual to communicate the need for immediate assistance in case of an emergency
Unit of Service	1 installation fee, 1 monthly rental fee
Activities Allowed	The following activities are included in Personal Emergency Response System Supports: • Installation of a personal emergency response system • Monthly cost of a personal emergency response system up to $52.07/month
Activities Not Allowed	Reimbursement is not available for Personal Emergency Response System Supports in the following circumstances: • When the service can be reimbursed through the Medicaid State Plan or a Medicaid HCBS waiver
Service Standards	Personal Emergency Response System Supports shall be reflected in the Individualized Support Plan • Services must address the needs identified in the person centered planning process and outlined in the Individualized Support Plan • **BDDS must authorize the personal emergency response system prior to the system being installed.**
Provider Qualifications	To be approved to provide Personal Emergency Response System Supports, and applicant shall: • (1) Be licensed, certified, registered or otherwise properly qualified under federal, state, or local laws applicable to the particular service that the applicant wishes to perform; **and** • (2) Certify that, if approved, the entity will perform these services in compliance with federal, state, or local laws applicable to a personal emergency response system
Documentation	Personal Emergency Response System Supports Standards

documentation must include:

- Identified in the Individualized Support Plan
- Documentation of expense for installation
- Documentation of monthly rental fee
- Documentation in compliance with 460 IAC 6

Physical Therapy Services	Physical Therapy Services means services provided under this article by a licensed physical therapist
Unit of Service	¼ hour (15 minutes)
Activities Allowed	Physical Therapy Services, consisting of the full range of activities provided by a licensed physical therapist, may include: • Screening and assessment • treatment and training programs designed to preserve and improve abilities for independent functioning, such as gross and fine motor skills, range of motion, strength, muscle tone, activities of daily living • Planning and reporting • Direct therapeutic intervention • Training and assistance with adaptive aids and devices • Consultation or demonstration of techniques with other service providers and family members • Participating on the interdisciplinary team, when appropriate, for the development of the service plan
Activities Not Allowed	Individual Physical Therapy Services will not be reimbursed under the following circumstances: • Activities not delivered one-on-one with the individual • Activities delivered in a nursing facility • Activities available through the Medicaid State Plan (i.e., a Medicaid State Plan prior

authorization denial is required before reimbursement is available through BDDS for this service)

Service Standards	Individual Physical Therapy Services must be reflected in the Individualized Support Plan • The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan
Provider Qualifications	To be approved to provide Physical Therapy Services as a **physical therapist**, an applicant shall: • Be a physical therapist licensed certified under IC 25-27-1 To be approved to provide Physical Therapy Services as a **physical therapist's assistant**, an applicant shall: • Be a physical therapist's assistant certified under IC 25-27-1 • For an entity to be approved to provide Physical Therapy Services, the entity shall certify that, if approved, the entity will provide physical therapy services using only persons who meet the qualifications set out in 460 IAC 6-5-19
Documentation Standards	Physical Therapy Services documentation must include: • Documentation by appropriate assessment • Services outlined in the Individualized Support Plan • State contracted day service providers must have proof of not-for-profit status • Appropriate credentials for service provider • Attendance record, therapist logs and/or chart detailing service provided, date and times. • Documentation in compliance with 460 IAC 6

Pre-Vocational Services

Pre-vocational services means services aimed at preparing an individual for paid or unpaid employment, by teaching such concepts as compliance, attendance, task completion, problem solving and safety

This service is a component of Day Services

Unit of Service

¼ hour (15 minutes)

Activities Allowed

The following activities are included in pre-vocational services:

- Activities that are not primarily directed at teaching specific job skills, but at underlying habilitative goals
- Supervision, monitoring, training, education, demonstration, or support in:
  - Maintaining regular attendance
  - Increasing attention span for specific tasks
  - Understanding and following workplace standards
  - Other skills needed to gain and maintain paid or unpaid employment

Activities Not Allowed

Reimbursement through pre-vocational services does not cover:

- Services available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142.
- Job coaching or other skills related to a specific job

Service Standards

Pre-vocational services must be reflected in the Individualized Support Plan

- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan

	• Services must complement other services the individual receives and enhance increasing independence for the individual • Two short break periods (up to 15 minutes in the morning and in the afternoon) may be included
Provider Qualifications	To be approved to provide Prevocational Services, an applicant shall: • Meet the requirements for direct care staff set out in 460 IAC 6-14-5 • For an entity to be approved to provide Prevocational Services, the entity shall certify that, if approved, the entity will provide prevocational services using only persons who meet the qualifications set out in 460 IAC 6-14-5
Documentation Standards	Pre-vocational services documentation must include: • Not-for-Profit status • BDDS approved provider • Services outlined in the Individualized Support Plan • Attendance record documenting the complete date and time entry (including a.m. or p.m.) and the number of units of service delivered that day • Documentation that wages for activity are at or below 50% of Federal Minimum Wage • Documentation that supports compliance with staffing ratios per the individual's service planner • Documentation in compliance with 460 IAC 6
Recreational Therapy Services	Recreational Therapy Services means services provided under this article and consisting of a medically approved recreational program to restore, remediate, or rehabilitate an individual in order to (1) improve the individual's functioning and independence and (2) reduce or eliminate the effects of an individual's disability
Unit of Service	¼ hour (15 minutes)
Activities Allowed	The following activities are included in Recreational Therapy Services:

- Planning, organizing and directing:
  - Adapted sports
  - Dramatics
  - Arts and crafts
  - Social activities
  - Other recreation services designed to restore, remediate or rehabilitate

Activities Not Allowed	Reimbursement is not available for Recreational Therapy Services in these circumstances: • For payment for the actual activities being planned, organized and directed
Service Standards	Recreational Therapy Services should be reflected in the Individualized Support Plan of the individual • Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan • Services must complement other services the individual receives and enhance increasing independence for the individual
Provider Qualifications	To be approved to provide Recreational Therapy Services, an applicant shall: • Be certified by the National Council for Therapeutic Recreation Certification • Certify that, if approved, the entity will provide Recreational Therapy Services using only persons who meet the qualifications set out in 460 IAC 6-5-22
Documentation Standards	Recreational Therapy Services documentation must include: • Documentation by appropriate assessment • Services outlined in Individualized Support Plan • Appropriate credentials for service provider • Attendance record, therapist logs and/or chart detailing service provided, date and times

- Documentation in compliance with 460 IAC 6

Rent and Food for Unrelated Live-in Caregiver Supports	Rent and Food for an Unrelated, Live-in Caregiver Supports means the additional cost an individual incurs for the room and board of an unrelated, live-in caregiver as provided for the individual's ICLB
Actual Cost	Up to $545/month
Activities Allowed	Reimbursement is available through Rent and Food for an Unrelated Live-in Caregiver for the following: • The individual receiving these services lives in his/her <u>own</u> home • For payment to not be considered income for the individual receiving services, payment for the portion of the costs of rent and food attributable to an unrelated, live-in caregiver must be made directly to the live-in caregiver • Room and board for the unrelated live-in caregiver (who is not receiving any other financial reimbursement for the provision of this service) ° Room: shelter type expenses including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities and related administrative services ° Board: three (3) meals a day or other full nutritional regimen ° <u>Unrelated</u>: unrelated by blood or marriage to any degree ° Caregiver: an individual providing a covered service as defined by BDDS service definitions or in a Medicaid HCBS waiver, to meet the physical, social or emotional needs of the individual receiving services
Activities Not Allowed	Reimbursement is not available for Rent and Food for an Unrelated Live-in Caregiver under the following circumstances: • When the individual lives in the home of the

caregiver or in a residence owned or leased by the provider of other services, including Medicaid waiver services

- When the live-in caregiver is related by blood or marriage (to any degree) to the individual

Service Standards

Rent and Food for an Unrelated Live-in Caregiver should be reflected in the Individualized Support Plan of the individual

- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan
- Services must complement other services the individual receives and enhance increasing independence for the individual
- The person centered planning team will decide and assure that the individual who will serve as a live-in caregiver has the experience, skills, training and knowledge appropriate to the individual and the type of support needed

Provider Qualifications

To be approved to provide Rent and Food for Unrelated Live-in Caregiver Supports, an applicant shall:

- Be approved to provide:
  - (1) Community Habilitation and Participation Services; or
  - (2) Residential Habilitation and Support Services under 460 IAC 6

Documentation Standards

Rent and Food for Unrelated Live-in Caregiver documentation must include:

- Identified in the Individualized Support Plan
- Documentation of how amount of Rent and Food was determined
- Receipt that funds were paid to the individual
- Documentation in compliance with 460 IAC 6

Residential Habilitation And Support Services	Residential Habilitation and Support service providers are responsible for the health, safety and welfare of the individual, and assist in the acquisition, improvement, and retention of skills necessary to support individuals to live successfully in their own homes
Unit of Service	Daily rate based on the needs of the individual
Activities Allowed	Residential Habilitation and Support services activities include direct supervision, monitoring and training to implement the Individualized Support Plan (ISP) outcomes for the individual through the following: • Assistance with personal care, meals, shopping, errands, chore and leisure activities and transportation (excluding transportation that is covered under the Medicaid State Plan) • Coordination and facilitation of medical and non-medical services to meet healthcare needs, including physician consults, medications, development and oversight of a health plan, utilization of available supports in a cost effective manner and maintenance of each individual's health record • Assurance that direct service staff are aware and active participants in the development and implementation of ISP and Behavior Support Plans
Activities Not Allowed	Residential Habilitation and Support services do not include the following situations: • Services furnished to a minor by the parent(s), step-parent(s) or legal guardian • Services furnished to an individual by the person's spouse • Services to individuals in Adult Foster Care or Children's Foster Care • Services that are available under the Medicaid State Plan • Services furnished to an adult individual by a parent, step-parent or guardian, that exceed forty (40) hours per week

Service Standards

Residential Habilitation and Support services must be reflected in the Individualized Support Plan (ISP)

- Services must address needs identified in the person centered planning process and be outlined in the ISP
- Providers of Residential Habilitation and Support services must meet the training requirements for employees set out in 460 IAC 6-14-4

Provider Qualifications

To be approved to provide Residential Habilitation and Supports an applicant shall:

- Meet the requirements for direct care staff set out in 460 IAC 6-14-5
- An entity shall certify that, if approved, the entity will provide Residential Habilitation and Support services using only persons who meet the qualifications set out in 460 IAC 6-14-5, 6-5-30 and 6-5-14

Documentation Standards

Residential Habilitation and Support services documentation must include:

Documentation for Billing:

- Approved provider
- The provider must use the approved participant attendance record. Each entry must include the initials of the individual who completes the daily entry. The provider maintains a list of staff who complete the form listing staff name and initials used.

Clinical/Progress Documentation:

- The provider completes a monthly summary of the individual's progress toward outcomes, using the approved form. This is a narrative summary, about one page in length, that describes the individual's residential habilitation supports activities, and must address outcomes in the individual's ISP, as well as a high level summary of issues affecting the health, safety and welfare of the individual requiring intervention by a healthcare professional, case manager, behavior support services provider or BDDS staff member.

- This documentation will be reviewed as part of the BQIS quality reviews. Failure to maintain these monthly summaries as described above will be considered a violation of the Medicaid provider agreement and reimbursement for services will not be available.

Residential Living Allowance and Management Services

Residential Living Allowance Management Services means services that assist an individual in managing the individual's residential living allowance supports

Residential Living Allowance means funds authorized by the BDDS services under IC 12-11-1.1-2(c) to cover the actual costs of room and board expenses as authorized in the individual's budget through state funding

This service is only reimbursable through state funded services (not available through Medicaid Waiver services)

Note: New requests for RLAS for minor children living outside of the home of the parent or guardian will not be approved by BDDS without the explicit approval of the Director of BDDS

Unit of Service

One unit equals the total amount of the residential living expenses minus the total income and benefits of the individual

Activities Allowed

Reimbursement is available for a Residential Living Allowance and Management Services under the following circumstances:

- The individual is receiving state supported residential services or receiving those waivers (i.e., priority, deinstitutional) that have state dollars allocated and approved by the legislature, budget agency, and FSSA/DDRS to support the residential living expenses
- The individual's living expenses exceed the benefits and income
- The provider has the responsibility to see that the individual's budget does not exceed the limits
- The provider will be reimbursed for the costs already paid (cost reimbursement)

Activities Not Allowed

Reimbursement is not available for a Residential Living Allowance and Management Services under the following circumstances:

- When the individual' s benefits and income exceed living expenses
- When the adult or minor child is residing in a family member's home, including parents or siblings or grandparents

Service Standards

The Residential Living Allowance and Management Services must be reflected in the individual community living budget

- The Bureau of Developmental Disabilities will cap the total amount for a Residential Living Allowance. The amount is based on 150% of the Federal Poverty Level. BDDS must also approve any exceptions to the cap for a Residential Living Allowance, by the appropriate process established by the BDDS

- The Residential Living Allowance and Management Services will be developed within the Individual Community Living Budget (ICLB) process. The residential services provider submits the proposed initial residential living expenses. Thereafter, the residential services provider submits revisions, when warranted by changing circumstances, and 60 days prior to the expiration of the current ICLB. All budgets must be approved by BDDS

- The Residential Living Allowance and Management Services will be approved by the BDDS, prior to implementation of the budget

- The provider has a current contract with BDDS to manage Residential Living Allowance and Management Services dollars

- The Individual Community Living Budget (ICLB) is used to determine the amount of the residential living allowance

- Expenses that are not paid on a monthly basis (e.g., non-insured medical expenses or quarterly insurance premiums) **must** be pro-rated on a monthly basis and deposited in the individual's

	bank account to insure their availability at the time the expenses are due
Provider Qualifications	To be approved to provide Residential Living Allowance and Management Services, an applicant shall: • Be approved to provide either: ° (1) Residential Habilitation and Support Services; or ° (2) Community Habilitation and Participation Services under 460 IAC 6
Documentations Standards	Residential Living Allowance and Management Services documentation must include: • BDDS approved provider • Itemized list of expenditures, with receipts • Documentation in compliance with 460 IAC 6
Respite Care Services	Respite care services means services provided to individuals unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care
Unit of Service	¼ hour (15 minutes) Respite can be provided in the individual's home/place of residence, in the caregiver's home, in an Adult Day Services (formerly adult day care) facility, or in a non-private residential setting (i.e., a "respite home")
Limits/Guidelines	Respite services may not exceed $2,000 per year Unless approved by the Exception Review Team***** ***Note** – Budgets submitted that request Respite services in excess of $2,000 per year will be reviewed by the Exception Review Team
Activities Allowed	Respite may include the following activities: • Assistance with toileting and feeding • Assistance with daily living skills, including assistance with accessing the community and

community activities

- Assistance with grooming and personal hygiene
- Meal preparation, serving and clean up
- Administration of medications
- Supervision

Activities Not Allowed

Some services are not reimbursable through Respite, including:

- Reimbursement for room and board
- Services provided with the intent of covering for the time a caregiver is at work
- Services provided by the parent of a minor child or an adult individual's spouse
- Services provided to individuals living in a licensed facility based setting
- Skilled services being performed by an un registered or unlicensed nurse
- The cost of registration fees or the cost of recreational activities (e.g. camp, etc.)
- When the service of Adult Foster Care or Children's Foster Care is being furnished to the individual

Service Standards

Respite care must be reflected in the Individualized Support Plan

Provider Qualifications

To be approved to provide Respite Care Services, an applicant shall:

- Meet the requirements for direct care staff set out in 460 IAC 6-14-5 application shall meet the requirements for direct care staff set out in 460 IAC 6-14-5
- An entity must meet both (1) and (2):

(1) Be one of the following types of entities:
  - A licensed home health agency;

- An approved adult day service provider under this article (460 IAC 6); or
- An entity providing residential services to unrelated individuals

(2) Certify that, if approved, the entity will provide respite care services using only persons who meet the direct care staff qualifications set out in 460 IAC 6-14-5

Documentation Standards

Respite Care Services documentation must include:

- BDDS approved provider
- Identified in the Individualized Support Plan
- Documentation must include the following elements: the reason for the respite, the location where the service was rendered and the type of respite rendered (e.g. Respite HHA)
- Data record of staff to individual service documenting the complete date and time entry (including a.m. or p.m.) and the number of units of service delivered that day
- Each staff member who spends more than thirty (30) minutes that day in direct supervision or care of an individual must make at least one entry on each day service, describing an issue or circumstance concerning the individual. The entry should include time and date of entry and at least the last name and first initial of the staff person making the entry
- If the person providing the service is required to be professionally licensed, the title of the individual must also be included. For example, if a nurse is required, the nurse's title should be documented
- Any significant issues involving the individual requiring intervention by a Health Care Processional, case manager or BDDS staff member are also to be documented
- Documentation that supports compliance with staffing ratios per the individual's service planner
- Documentation in compliance with 460 IAC 6

Specialized Medical Equipment and Supplies Supports	Specialized Medical Equipment and Supplies Supports means devices, controls or appliances that (1) enable an individual to increase the individual's abilities to perform activities of daily living or perceive or control the environment; or (2) enhance an individual's ability to communicate **BDDS must authorize any equipment or supplies prior to the items being purchased**
Unit of Service	Unit for assessments: ¼ hour (15 minutes) Unit for Modifications - Installation: 1 job Unit for Maintenance: 1 job Reimbursement for Specialized Medical Equipment and Supplies Supports has an annual $300 limit for maintenance and repairs For those individuals receiving services on the Support Services Waiver, reimbursement for Specialized Medical Equipment and Supplies Supports has a lifetime cap of $7,500
Activities Allowed	The following list includes examples of items that are reimbursable Specialized Medical Equipment and Supplies Supports: • Items necessary for life support • Adaptive equipment and supplies • Ancillary supplies and equipment needed for the proper functioning of Specialized Medical Equipment and Supplies Supports, including Music Therapy supplies • Vehicle Modifications • Communication devices • Interpreter services • Durable and non-durable medical equipment • Servicing and repair of these items • Evaluation for items costing more than $500 by a qualified professional (physician, nurse, OT, PT, speech and language therapist, rehabilitative engineer, etc.)
Activities Not Allowed	Reimbursement is not available for Specialized Medical Equipment and Supplies Supports in these instances: • When the equipment and supplies can be reimbursed through the Medicaid State Plan or a

Medicaid HCBS waiver
- The items are not of direct medical or remedial benefit to the individual

Service Standards	Specialized Medicaid Equipment and Supplies Supports shall be reflected in the Individualized Support Plan • Equipment and supplies must address needs identified in the person centered planning process be included in the Individualized Support Plan • Evaluation required for items costing more than $500 by a qualified professional (physician, nurse, OT, PT, speech and language therapist, rehabilitative engineer, etc.) • Equipment and supplies must be for the direct medical or remedial benefit of the individual • All items shall meet applicable standards of manufacture, design and installation
Provider Qualifications	To be approved to provide Specialized Medical Equipment and Supplies Supports, an applicant shall: • (1) Be licensed, certified, registered or otherwise properly qualified under federal, state or local laws applicable to the particular service that the applicant desires to perform; and • (2) Certify that, if approved, the provider will perform the services in compliance with federal, state or local laws applicable to the type of equipment and supplies being provided
Documentation Standards	Specialized Medical Equipment and Supplies documentation must include: • Identified need in Individualized Support Plan • Identified direct medical benefit for the individual • Documented “Prior Authorization Denial” from Medicaid, if applicable • Receipts for purchases • Documentation in compliance with 460 IAC 6

Speech-Language Therapy Services*	Speech-Language Therapy Services means services provided by a licensed speech pathologist under 460 IAC 6
Unit of Service	¼ hour (15 minutes)
Activities Allowed	Speech-Language Therapy Services that are reimbursable include: • Screening • Assessment • Direct therapeutic intervention and treatment for speech and hearing disabilities such as delayed speech, stuttering, spastic speech, aphasic disorders, injuries, lip reading or signing, or the use of hearing aids • Evaluation and training services to improve the ability to use verbal or non-verbal communication • Language stimulation and correction of defects in voice, articulation, rate and rhythm • Design, fabrication, training and assistance with adaptive aids and devices • Consultation demonstration of techniques with other service providers and family members • Participating on the interdisciplinary team, when appropriate, for the development of the plan
Activities Not Allowed	Reimbursement is not available through individual Speech-Language Therapy Services for some services, including: • Time spent in planning, reporting and write-up • Services available through the Medicaid State Plan (i.e., a Medicaid State Plan prior authorization denial is required before reimbursement is available through BDDS for this service.) • Activities delivered in a nursing facility
Service Standards	Individual Speech-Language Therapy Services must be reflected in the Individualized Support Plan

- To be eligible for this service, the individual must have been examined by a certified audiologist and/or a certified speech therapist who has recommended a formal speech/audiological program

- The need for such services must be documented by an appropriate assessment and authorized in the individual's service plan

Provider Qualifications

To be approved to provide Speech-Language Therapy Services as a **Speech-Language Pathologist** an applicant shall:

- Be a speech-language pathologist licensed under IC 25-35.6

° To be approved to provide Speech-Language Therapy Services as a **Speech-Language Aide**, an applicant shall be:

- (1) A speech-language pathology aide as defined in IC 25-35.6-1-2;and
- (2) registered pursuant to 880 IAC 1-2

- For an entity to be approved to provide Speech-Language Therapy Services, the entity shall certify that, if approved, the entity will provide speech-language therapy services using only persons who meet the qualifications set out in 460 IAC 6-15-28

Documentation Standards

Speech-Language Therapy Services documentation must include:

- Documentation of an appropriate assessment
- Services outlined in the Individualized Support Plan
- State contracted day service providers must have proof of not-for-profit status
- BDDS approved provider
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing service provided, date and times.
- Documentation in compliance with 460 IAC 6

Under 460 IAC 3.5 (Rates for Adult Day Services) Speech Language Therapy Services is defined as *"Group Speech Therapy/Individual Speech Therapy".

Supported Employment Follow-Along Services

Supported Employment Follow-Along Services means services and supports that enable an individual to maintain paid employment if the individual is paid at or above the federal minimum wage

To be eligible for Supported Employment Follow-Along Services, an individual must have made the transition from Vocational Rehabilitation Services, at some point in the individual's career, to supported employment services

This service is a component of Day Services

In the following situations:

- Job in jeopardy – the individual will lose his/her job without additional intervention, or
- Career advancement – it is determined that the new job requires more complex, comprehensive, intensive supports than can be funded within the SEFA caps, or
- Job loss, the individual must be referred back to Vocational Rehabilitation for services

In the situations listed above, up to 10 hours of SEFA can be used for the job in jeopardy, career advancement, or job loss while the VR case is being reopened.

Unit of Service: 1 hour (60 minutes), up to annual cap

Annual Cap for Service: Annual caps:

- Individuals working <u>5 hours or more a week</u> = up to $4,500 annually*****
- Individuals working <u>less than 5 hours a week</u> = up to $2,250 annually*****

*** "**Annually" means a 12 month period that starts when the individual begins Supported Employment Follow-Along Services, not a specific fiscal or calendar year

Activities Allowed

Reimbursement is available through Supported Employment Follow-Along Services for the following activities:

- This activity is mandatory. If the documentation does not indicate the time spent twice per month, the provider should not be reimbursed for any other activity listed below. Time spent at the individual's work site: observation and supervision of the individual, teaching job tasks and monitoring at the work site a minimum of twice a month, to ascertain the success of the job placement
- Staff time used in traveling to and from a work site
- At the request of the individual, off site monitoring may occur as long as the monitoring directly relates to maintaining a job
- Employment services occur in an integrated work setting. (See definition of "Integrated," page 42)
- The provision of skilled job trainers who accompany the individual for short-term job skill training at the work site to help maintain employment
- Regular contact and/or follow-up with the employers, individuals, parents, family members, guardians, advocates or authorized representatives of the individuals, and other appropriate professional and informed advisors, in order to reinforce and stabilize the job placement
- Facilitation of natural supports at the work site
- Individual program development, writing tasks analyses, monthly reviews, termination reviews and behavioral intervention programs
- Advocating for the individual , but
  - only with persons at the employment site (i.e., employers, co-workers, customers) and only for purposes directly related to employment; OR

- with persons not directly affiliated with the employment site (i.e., parents, bus drivers, case managers, school personnel, landlords, etc.) if the person is hired and currently working

Activities Not Allowed

Reimbursement is not available under Supported Employment Follow-Along services for the following activities:

- Transportation of an individual participant. (Transportation costs may be billed under Transportation Services – Title XX or under waiver transportation services)
- Any service that is otherwise available under the Rehabilitation act of 1973 or Public Law 94-142
- Activities taking place in a group, i.e., work crews or enclaves
- Public relations
- Community education
- In-service meetings, department meetings, individual staff meetings, staff development
- Incentive payments made to an employer to subsidize the employer's participation in a supported employment program
- Payments that are passed through to users of supported employment programs
- Sheltered work observation
- Payments for vocational training that is not directly related to an individual's supported employment program
- Any other activities that are non-individual specific – e.g., the job coach is working the job instead of the individual when the individual is not present.
- Any activities which are not directly related to the individual's vocational plan

Service Standards

Supported Employment Follow-Along services must be reflected in the Individualized Support Plan

- Services are tailored to the needs and interests identified in the person centered planning process and must be outlined in the Individualized Support Plan

- The individual must have
  - Made the transition from Vocational Rehabilitation Services, or
  - Have lost his/her job and requires less than 10 hours of job development

Provider Qualifications

To be approved to provide supported Employment Services, an applicant shall meet the following requirements:

- (1) Be accredited by, or provide proof an application to seek accreditation from, one of the following organizations:

  (A) Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor;
  (B) The Council on Quality and Leadership in Supports for People with Disabilities, or its successor;
  (C) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor;
  (D) The National Commission on Quality Assurance, or its successor; or
  (E) An independent national accreditation organization approved by Secretary of FSSA

- (2) Certify that, if approved, the applicant will provide services using only persons who meet the qualifications set out in 460 IAC 6-14-5

Documentation Standards

Supported Employment Follow-Along Services documentation must include:

- Referral from Vocational Rehabilitation
- Identified in the Individualized Support Plan
- BDDS approved provider

- Data record of staff to individual service documenting the complete date and time entry (including a.m. or p.m.) and the number of units of service delivered that day
- At least one entry on each day service is provided, indicating participation in activity
- Documentation in compliance with 460 IAC 6

Therapy Services Therapy Services means services provided under 460 IAC 6-3-56 by a licensed psychologist with an endorsement as a health service provider in psychology, a licensed marriage and family therapist, a licensed clinical social worker, or a licensed mental health counselor

Unit of Service ¼ hour (15 minutes)

Activities Allowed The following activities are included in Therapy Services :

- Individual counseling
- Biofeedback
- Individual-centered therapy
- Cognitive behavioral therapy
- Psychiatric services
- Crisis counseling
- Family counseling
- Group counseling
- Substance abuse counseling and intervention

Activities Not Allowed Reimbursement is not available for Therapy Services in these circumstances:

- When services are reimbursable through the Medicaid State Plan or through a Medicaid HCBS waiver

Service Standards Therapy Services should be reflected in the Individualized Support Plan of the individual

- Services must address needs identified in the person centered planning process and be outlined in the Individualized Support Plan

- Services must complement other services the individual receives and enhance increasing independence for the individual

Provider Qualifications

To be approved to provide Therapy Services an applicant shall be:

  - (1) A psychologist licensed under IC 25-33-1 **and have an endorsement as a health service provider in psychology (HSPP) pursuant to IC 25-33-1-5.1(c);**
  - (2) A marriage and family therapist licensed under IC 25-23.6;
  - (3) A clinical social worker licensed under IC 25-23.6; or
  - (4) A mental health counselor licensed under IC 25-23.6

- For an entity to be approved to provide Therapy Services, the entity shall certify that, if approved, the entity will provide Therapy Services using only persons who meet the qualifications set out in 460 IAC 6-5-21

Documentation Standards

Therapy Services documentation must include:

- Documentation by appropriate assessment
- Services outlined in the Individualized Support Plan
- Appropriate credentials for service provider
- Attendance record, therapist logs and/or chart detailing service provided, date and times
- Documentation in compliance with 460 IAC 6

Transportation Services Title XX SSBG

Transportation means transporting an individual to and from his or her place of residence or a specified pick-up point to the location where services are delivered in order to support the individual in the community

This service is a component of Day Services

This service is only reimbursable through state funded services (not available through Medicaid Waiver services)

Unit of Service	1 round trip
Activities Allowed	Reimbursement for transportation is available in the following circumstances: • The individual is being transported to and from Supported Employment Follow-Along (although this is considered to be temporary until other generic transportation supports can be arranged) • Transportation occurs as part of Individual Habilitation (CHPI), only under the direct component • Transportation is reimbursable from the individual's residence or a specified pick-up point to the location where services are being delivered and the return trip • Transportation must be included in the individual's written service plan as a means to support specific services within the community
Activities Not Allowed	Reimbursement is not available for transportation under the following circumstances: • Transportation that is reimbursable through other funding sources such as Medicaid • Transportation for any other purpose than what is specifically addressed in the individual's service plan to support the individual in the community
Service Standards	Transportation services must be documented in agency files • One round trip of transportation per person per day is the maximum that can be billed • If an individual is transported only one way, one-half transportation units may be accumulated on a monthly basis, so those round-trip units may be billed at the end of the month
Provider Qualifications	To be approved to provide Transportation Services, an applicant shall be one (1) of the following: ◦ (1) A community mental retardation and other developmental disabilities centers ◦ (2) A community mental health center ◦ (3) A child care center licensed pursuant to IC 12-17-.2-2-4 ◦ (4) Otherwise approved under 460 IAC

- To be approved to provide transportation services, an applicant shall certify that, if approved, transportation services will be provided using only persons having a valid Indiana:
    - (1) Operator's license
    - (2) Chauffeur's license
    - (3) Public passenger chauffeur's license or
    - (4) Commercial driver's license; issued to the person by the Indiana bureau of motor vehicles to drive the type of motor vehicle for which the license was issued

- Provider of Transportation Services shall ensure that an individual is transported only in a vehicle:
    - (1) Maintained in good repair;
    - (2) Properly registered with the Indiana bureau of motor vehicles or in the state in which the owner of the vehicle resides; and
    - (3) Insured as required under Indiana law

- Provider of Transportation Services shall secure liability insurance for all vehicles owned or leased by the provider and used for transportation of an individual receiving services

- The liability insurance required by 460 IAC 6-34-3 (a) shall cover personal injury, loss of life, or property damage to an individual if the loss, injury, or damage occurs during the provision of Transportation Services to the individual by the provider

Documentation Standards

Transportation Services documentation must include:

- Identification in the Individualized Support Plan
- Proof of not-for-profit status
- Vehicle maintenance and liability insurance records for agency owned/operated vehicles
- For staff driving private vehicles, proof of insurance (record of carrier and policy number)

- Valid Indiana driver's license for staff (or license from staff's state of residence)
- At least one entry per round trip, to include complete date, individual's name and destination or activity
- Documentation that supports compliance with staffing ratios per the individual's service planner
- Documentation in compliance with 460 IAC 6

Transportation Supports	Transportation Supports means supports, such as tickets and passes to ride on public transportation systems that enable an individual to have transportation for access to the community **This service is a component of Day Services and Residential Habilitation and Supports**
Unit of Service	1 unit = 1 pass, ticket, etc.
Activities Allowed	Reimbursement for Transportation Supports is available in the following circumstances: • Costs of Transportation Supports are included in the monthly amounts paid under Transportation Services
Activities Not Allowed	Reimbursement for Transportation Supports is not available in the following circumstances: • Transportation that is available under the Medicaid State Plan • Ticket, passes, etc, that are purchased for staff, family members, or anyone other than the individual
Service Standards	Transportation Supports must be documented in agency files • Transportation Supports, if needed, should be documented in the individual's support plan
Provider Qualifications	Qualified agencies approved to provide Transportation Supports must meet the following requirements: • An applicant shall be otherwise approved to provide supported living services under 460 IAC 6

Documentation Standards	Transportation Supports documentation must include: • Identified in Individual Support Plan • Receipts for passes, tickets, etc. • At least one entry per round trip, to include complete date, client name and destination or activity • Documentation in compliance with 460 IAC 6